

Name of Camper: _____

Summer Camp Health History

Make sure to complete **ALL 3 Pages** – front and back. The last page must be **signed** by the Parent and/or Guardian.

Camper Info:

Name of camper: _____

Parents/Guardian: _____

Home Phone (____) _____

Mother's place of employment: _____

Mother's Work Phone (____) _____ Mother's Cell Phone (____) _____

Father's place of employment: _____

Father's Work Phone (____) _____ Father's Cell Phone (____) _____

In case of emergency (and parent/guardian is unable to be reached) please notify:

1. Name: _____ **Relationship to camper:** _____

Phone: (____) _____ **2nd Phone:** (____) _____

Address, City, State, Zip: _____

2. Name: _____ **Relationship to camper:** _____

Phone: (____) _____ **2nd Phone:** (____) _____

Address, City, State, Zip: _____

Health History:

Has the individual had any of the following health problems? (check and give approximate dates)

Anemia _____ Sickle Cell Anemia _____ Asthma _____

Diabetes Type I (Insulin dependent) _____ Diabetes Type II _____

Heart disease _____ Rheumatic fever _____ Scarlet fever _____

Whooping cough _____

Seizure Disorder _____ Shunt – yes _____ no _____ If yes, what type of shunt? _____

Other _____

Does the individual have any allergies? *Be specific ~ Explain type of reaction or symptom(s)*

Insects (be specific) _____

Seasonal/inhaled _____

Foods _____

Antibiotics (be specific) _____

Other medications (give names) _____

Other _____

What steps should be taken if the camper is to come in contact with these known allergies? _____

Does the camper take medication? Yes _____ No _____ If yes, please list Medication(s) and reason for taking medication(s)

Are medications taken during camp hours (9:30-3:00)? Yes _____ No _____

If yes, you must also complete the medication authorization form within this packet.

Please complete both sides →

Name of Camper: _____

1) Does the camper have any problems in the use of arms, hands, legs, feet, walking, running or any coordination problems? Yes _____ No _____ If yes, please explain: _____

2) Does the camper require use of any special braces? Yes _____ No _____
Please explain if assistance is needed or possible problems:

3) Does camper use a wheelchair? Yes _____ No _____
What assistance is needed? _____
Can camper transfer? Yes _____ No _____

4) Is the camper able to use the toilet independently? Yes _____ No _____
If no, then what assistance does the camper require to use the bathroom?

5) Does the camper have accidents during the day? (ie bowel/urinary accidents) Yes _____ No _____
If help is needed, please explain: _____

6) Does the camper have any behavior problems? (Such as destructive; self abusive; aggressive)

7) Vision: Does the camper wear Glasses: Yes _____ No _____ Contact Lenses: Yes _____ No _____
Name of Visual Problem: _____

8) Hearing: Does the camper wear a hearing aid? Yes _____ No _____

9) Speech/Language: Does the camper have any speech/language difficulty? Please explain.

10) Dental: Does the camper wear braces: Yes _____ No _____

Has the individual had any of the following (explain):

11) Operations or Serious Injuries (Dates):

12) Chronic or Recurring Illness:

13) Other Diseases or details of above:

14) Would you consider the camper? Active _____ Quiet _____
Any favorite activities to be encouraged?

Any activities to be discouraged?

Name of Camper: _____

Does the individual: *(Please explain)*

15) Complain of headaches frequently? _____

16) Complain of stomach aches frequently? _____

17) Have a problem with diarrhea? _____

18) Have a problem with constipation? _____

19) Have a problem with recurrent infections or ongoing infections? _____

20) Have frequent ear infections/swimmers ear? _____

21) Have frequent strep throat? _____

22) Have any nervous habits? _____

23) (For girls) Has this person had her period? _____ If not, has she been told about it? _____

Is her period normal? (ie excessively heavy, painful) _____

If it is painful, does she take medication? Yes _____ No _____ (if yes, please complete medication authorization)

24) Special Considerations:

25) Does the camper dress independently? If help is needed, please explain:

26) Does the camper get regular exercise? (Specify):

27) Please answer the following questions regarding nutrition:
How would you describe the camper's appetite? (Good, Fair, Poor)

Are there any eating or swallowing difficulties? If help is needed, please describe:

**Is there anything more about the camper's health that you think is important for us to know?
(Especially possible medical emergencies)**

Physician Name: _____ Phone (_____) _____

I, the undersigned state that the health history provided to Catholic Charities Health & Human Services/Disability Services Camp Happiness is correct, to the best of my knowledge.

 ****Parent/Guardian** _____
Signature Date

*****Please notify the office if the individual is exposed to any communicable disease 3 weeks before camp***

Please complete both sides →